

10093

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10099

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age in especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY	St. Mary's	MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		LENGTH OF STAY <i>in this place</i> Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS		

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE	Maryland	COUNTY	St. Mary's
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN			Oakley
STREET ADDRESS		(If rural, give location)	

3. NAME OF
DECEASED:
(Type or Print)

Male

(First)
Joseph(Middle)
Aaron(Last)
Armstrong4. DATE
(Month) (Day) (Year)
OF
DEATH Oct. 25, 1955

Colored

6. COLOR OR
RACE:
Single7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)8. DATE OF BIRTH:
July 16, 19529. AGE last birthday:
3 yrs.10. IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?
U.S.A.

13. FATHER'S NAME:

Joseph Aaron Armstrong

14. MOTHER'S MAIDEN NAME:

Mary Elizabeth Butler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:

Joseph A. Armstrong Oakley, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

204
Immediate cause (a)
DUE TO

Myeloid leukemia

INTERVAL BETWEEN
ONSET AND DEATHAntecedent cause(s)
Diseases or conditions, if any. (b)
giving rise to the above cause DUE TO
stating underlying cause last (c)II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?
Yes No

21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY	21c. (City or town) (County) (State)
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21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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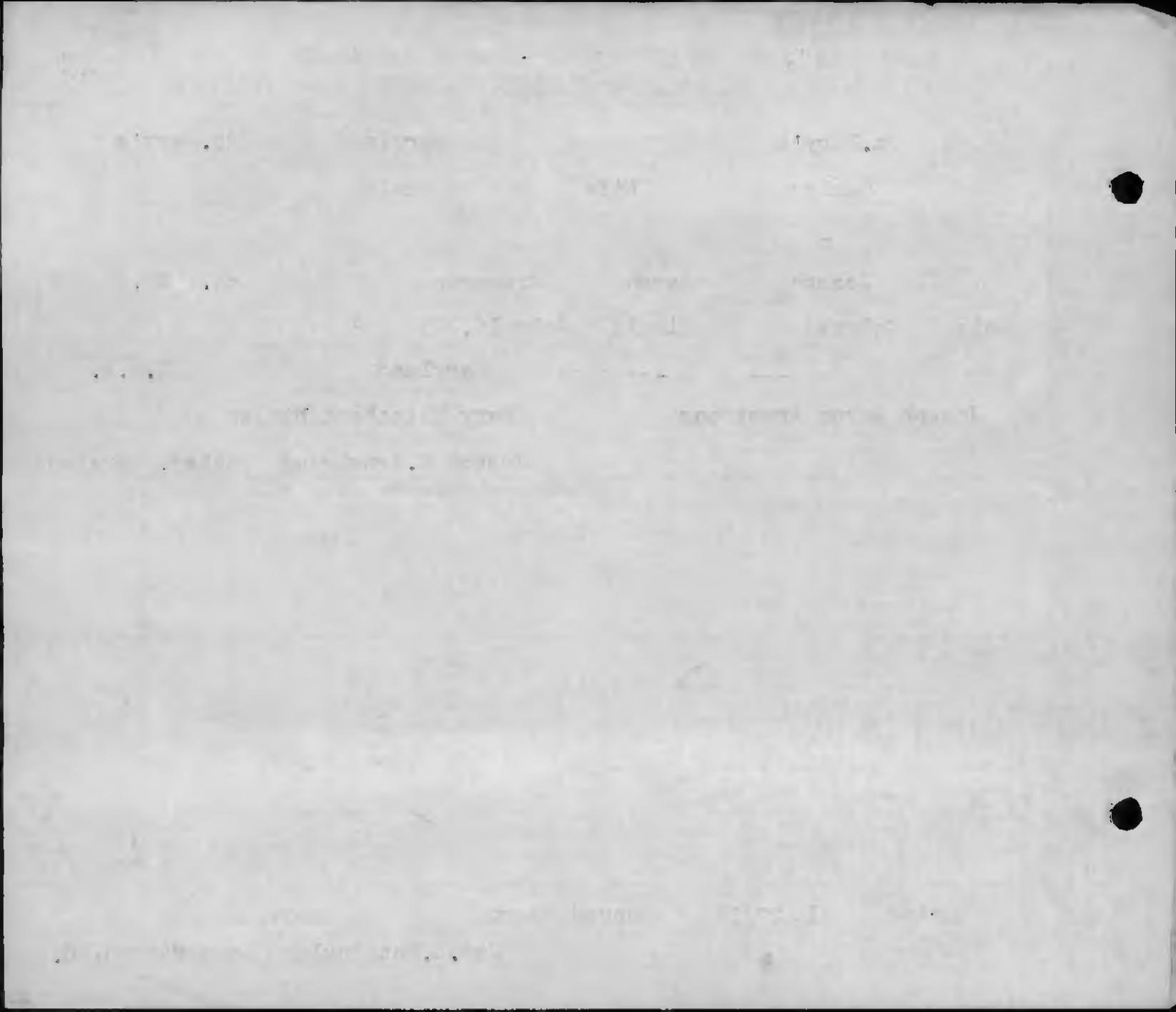
22. I hereby certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and find that death resulted from: Natural causes Accident Suicide Homicide Undetermined cause
SIGNATURE *Paul F. Green*

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): Buried	DATE THEREOF 10/27/55	NAME OF CEMETERY OR CREMATORIAL Sacred Heart	LOCATION (City, town, or county) (State) Bushwood
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DATE REC'D BY LOCAL REG. 10/25/55	REGISTRAR'S SIGNATURE <i>C. W. Hedrick</i>	24. FUNERAL DIRECTOR Jos. C. Mattingley	ADDRESS Leonardtown, Md.
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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 145 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10094

10100

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
CITY OR TOWN		COUNTY St. Mary's	MARYLAND	STATE Maryland		COUNTY St. Mary's	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		CITY (If outside corporate limits, write RURAL OR TOWN give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	
78 St. Mary's Hospital		Leonardtown		15 day's		Rural Great Mills	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH Oct. 25 1955			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH October 26, 1883	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad		10b. KIND OF BUSINESS OR INDUSTRY Clerk		9. AGE last birthday 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Alfred Morton Bulla				11. BIRTHPLACE (State or foreign country) North Carolina			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or N/A) N/A				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
16. SOCIAL SECURITY NO. 704-16-8427				14. MOTHER'S MAIDEN NAME Elizabeth Spencer			
17. INFORMANT & ADDRESS Mary L. Bulla Great Mills, Maryland				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, DUE TO GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)				INTERVAL BETWEEN ONSET AND DEATH 15 days 10 years Cerebral Hemorrhage General arteriosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Great Mills, Md.		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 10, 1955, to Oct. 25 1955, that I last saw the deceased alive on Oct. 25, 1955, and that death occurred at 11:10 A.M. from the causes and on the date stated above. SIGNATURE M.D. ADDRESS (Street, city, town, state) LOCATION (City, town, or county) DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/28/55		NAME OF CEMETERY OR CREMATORIUM Chestnut Hill		10/26/55 Salisbury, North Carolina	
24. REC'D BY REGISTRAR DATE Oct. 26/55		REGISTRAR'S SIGNATURE M. B. Bulla		25. FUNERAL DIRECTOR'S SIGNATURE J. C. Mottley		ADDRESS Leonardtown, Md.	

CEMETERY OF DEATH

PLAN OF CEMETERY OF DEATH

BUREAU V. S.

OCT 27 1955

RECEIVED

1955-22-CHIEF-111

16-111

INSTRUCTIONS**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10095

CERTIFICATE OF DEATH

10101

Reg. Dist. No.

282

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY <i>St. Marys</i>	MARYLAND <i>Compton</i>	LENGTH OF STAY (in this place)	STATE <i>Maryland</i>	COUNTY <i>St. Marys</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Compton</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>St. Clements Shores</i>			STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED (Type or Print) <i>William Rosevear Chaplin</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>10 - 17 - 1955</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>November 17, 1902</i>	9. AGE last birthday <i>52</i>	IF UNDER 1 YEAR Months Yrs. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Civil Service</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Frank J. Chaplin</i>			14. MOTHER'S MAIDEN NAME <i>Rhoda Rosevear</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>	16. SOCIAL SECURITY NO. <i>123-45-6789</i>		17. INFORMANT & ADDRESS <i>Mollie P. Chaplin - Compton, Maryland.</i>		
18. MEDICAL CERTIFICATION <i>200.1</i> IMMEDIATE CAUSE (A) <i>Cachexia, malnutrition</i> ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Lymphosarcoma</i>			INTERVAL BETWEEN ONSET AND DEATH <i>18 mos</i>		
19a. DATE OF OPERATION <i>19b. MAJOR FINDINGS OF OPERATION</i>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. <input type="checkbox"/> White <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Nov. 1953</i> to <i>Oct. 17, 1955</i> , that I last saw the deceased alive on <i>Oct. 17, 1955</i> , and that death occurred <i>10:50 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>J. Roy Guyter</i> ADDRESS (Street, city, town, state) <i>MacLanecoville</i> DATE SIGNED <i>10/18/55</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>10/19/55</i>	NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		LOCATION (City, town, or county) <i>Washington, D.C.</i> (State)	
24. REC'D BY REGISTRAR <i>Alma D. Housery</i>	REGISTRAR'S SIGNATURE <i>Dames</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>P.B. Robinson - Leonardtown, Md.</i>			
DATE <i>10-19-55</i>					

BUREAU V. 2

OCT 20 1955

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10096

10102

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	St. Mary's Leonardtown	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Charlotte Hall STREET ADDRESS (If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) OF DEATH Oct. 27, 1955	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH April 30, 1952
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Corinilous Dade		14. MOTHER'S MAIDEN NAME Mary E. Barns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Jos. E. Dade Charlotte Hall, Md.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 491X IMMEDIATE CAUSE (A) <i>Bilateral Bronchitis (Pneumonia)</i> INTERVAL BETWEEN ANTECEDENT CAUSE(S) DUE TO 5 days DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10/27, 1955, to 10/28, 1955, that I last saw the deceased alive on 10/27, 1955, and that death occurred at M, from the causes and on the date stated above. SIGNATURE: <i>Ward D. Dade</i> M.D. ADDRESS (Street, city, town, state) <i>Leonardtown, Md.</i> DATE SIGNED <i>10/27/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/28/55	
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORIAL Ebenezer	
REGISTRAR'S SIGNATURE Alfred Hauser		LOCATION (City, town, or county) Charlotte Hall, Md.	
DATE 10-28-55		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Alfred Hauser, Jr. & Mottley Leonardtown, Md.	

CHARGE OF GRAFT

60003

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BUREAU V. S

NOV 1 1995

FEDERAL BUREAU OF INVESTIGATION

2025 RELEASE UNDER E.O. 14176

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10103

10097

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY <input checked="" type="checkbox"/> TOWN	St. Marys	MARYLAND	STATE <input checked="" type="checkbox"/> TOWN	Maryland	COUNTY <input checked="" type="checkbox"/> TOWN
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		RURAL
HOSPITAL OR INSTITUTION OR STREET ADDRESS <input checked="" type="checkbox"/> 00		Wynn	Wynn		(If rural give location)
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
Estelle Cole Dominy			10 - 21 - 1955		
5. SEX <input checked="" type="checkbox"/> female	6. COLOR OR RACE <input checked="" type="checkbox"/> white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <input checked="" type="checkbox"/> married	8. DATE OF BIRTH <input checked="" type="checkbox"/> Aug. 25, 1890	9. AGE last birthday <input checked="" type="checkbox"/> 65 yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <input checked="" type="checkbox"/> Housewife			10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/> Domestic	11. BIRTHPLACE (State or foreign country) <input checked="" type="checkbox"/> Washington, D.C.	IF UNDER 24 HRS. Hours Min.
13. FATHER'S NAME <input checked="" type="checkbox"/> Charles D. Cole			14. MOTHER'S MAIDEN NAME <input checked="" type="checkbox"/> Augusta M. Geisler		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <input checked="" type="checkbox"/> no			16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/> 345-07-7142 B		
17. INFORMANT & ADDRESS <input checked="" type="checkbox"/> Carl G. Dominy - Wynn, Maryland.			18. MEDICAL CERTIFICATION		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <input checked="" type="checkbox"/> 332X IMMEDIATE CAUSE <input checked="" type="checkbox"/> Antecedent cause(s) DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last. <input checked="" type="checkbox"/> (B) DUE TO <input checked="" type="checkbox"/> (C)			INTERVAL BETWEEN ONSET AND DEATH <input checked="" type="checkbox"/> 1 month <input checked="" type="checkbox"/> 20 yrs.		
Cerebral Thrombosis Arterio - sclerosis					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <input checked="" type="checkbox"/> Labor & delivery, hypertension, heart disease					
19a. DATE OF OPERATION <input checked="" type="checkbox"/> none		19b. MAJOR FINDINGS OF OPERATION <input checked="" type="checkbox"/> none		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, <input checked="" type="checkbox"/> ANOTHER MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/> none		21c. WHERE DID INJURY OCCUR? (City or town) <input checked="" type="checkbox"/> none	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <input checked="" type="checkbox"/> none		21e. INJURY OCCURRED M. While at work F. Not while at work <input checked="" type="checkbox"/> none		21f. HOW DID INJURY OCCUR? <input checked="" type="checkbox"/> none	
22. I hereby certify that I attended the deceased from <input checked="" type="checkbox"/> 21/10/55 to <input checked="" type="checkbox"/> 10/21/55, 1955, that I last saw the deceased alive on <input checked="" type="checkbox"/> 10/20, 1955, and that death occurred at <input checked="" type="checkbox"/> 5:30A.M. from the causes and on the date stated above.					
SIGNATURE <input checked="" type="checkbox"/> ADDRESS (Street, city, town, state) <input checked="" type="checkbox"/> DATE SIGNED <input checked="" type="checkbox"/> 10/21/55					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <input checked="" type="checkbox"/> Burial		DATE THEREOF <input checked="" type="checkbox"/> 10/23/55		NAME OF CEMETERY OR CREMATORIAL <input checked="" type="checkbox"/> Trinity Cemetery	
24. REC'D BY REGISTRAR <input checked="" type="checkbox"/> Local		REGISTRAR'S SIGNATURE <input checked="" type="checkbox"/> P. B. Beary M.D.		LOCATION (City, town, or county) <input checked="" type="checkbox"/> St. Marys City, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE <input checked="" type="checkbox"/> P. B. Robinson - Leonardtown, Md.					
DATE <input checked="" type="checkbox"/> 10-21-55					

RECEIVED - BY MAIL TO THE STATE GOVERNOR.

STATE TO STATE TELEGRAM

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FEDERAL BUREAU OF INVESTIGATION

100-241955

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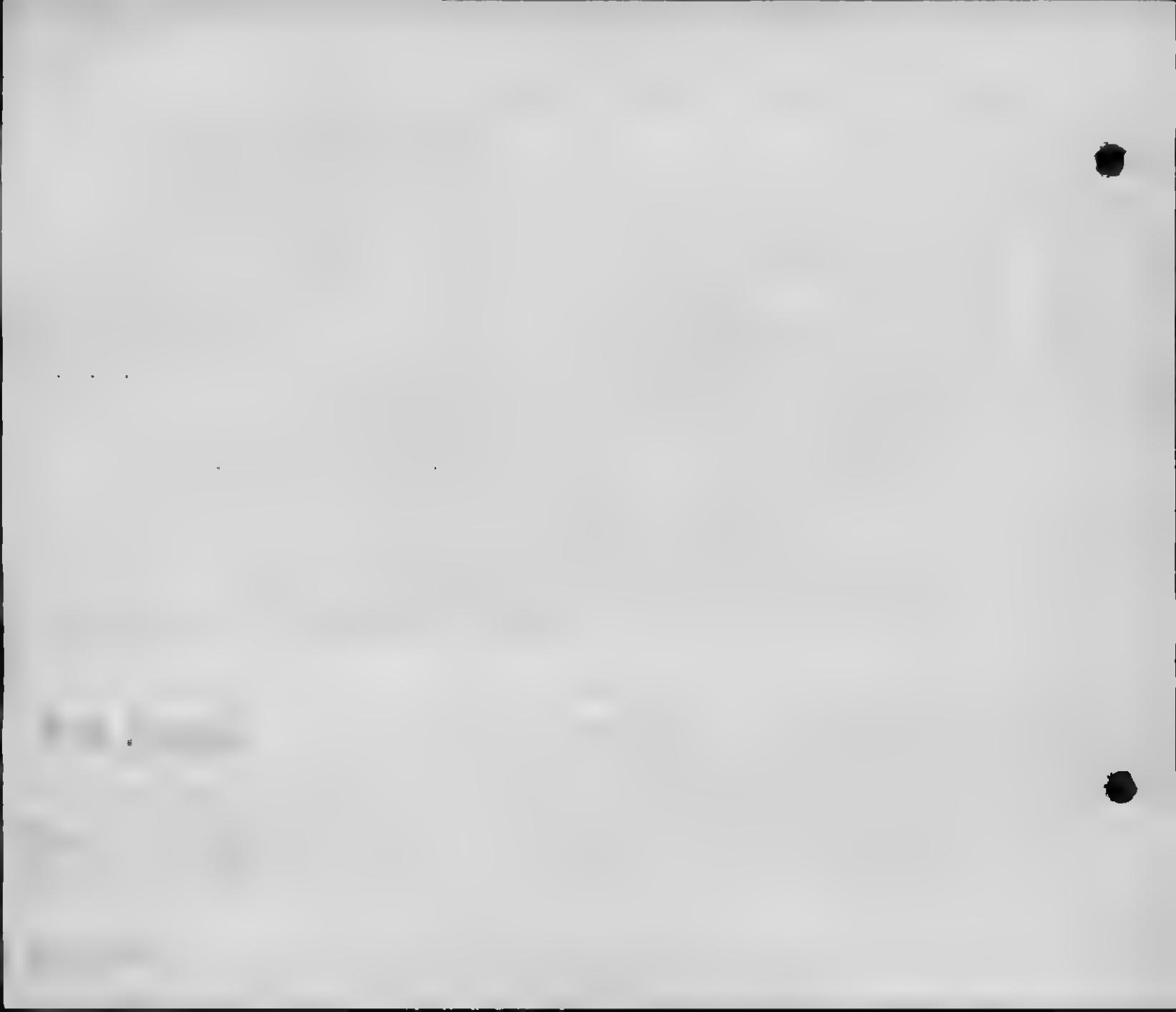
10104
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 287

1 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	St. Mary's Laurel Grove	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland COUNTY Saint Mary's CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Morganza		
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Rural	STREET ADDRESS	(If rural, give location) Rural		
3. NAME OF DECEASED: (Type or Print)		(First) John	(Middle) Columbus	(Last) HOLT	4. DATE OF DEATH: October 14, 1955
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 2 / 12 / 12	9. AGE last birthday: 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farming		10b. KIND OF BUSINESS OR INDUSTRY: Farm	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: Philip Holt		14. MOTHER'S MAIDEN NAME: Sarah Stewart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.: Vilot M. Coates * 309 U St. N.W., Wash. 1, DC		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 824X Immediate cause (a) ... DUE TO Antecedent cause(s) (b) ... Diseases or conditions, if any, (b) ... giving rise to the above cause DUE TO stating underlying cause last (c) ... Increased intracranial pressure Fractured skull					
2. INTERVAL BETWEEN ONSET AND DEATH immediate immediate					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none					
19a. DATE OF OPERATION: more		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, business) OF INJURY Laurel Grove, St. Mary's, Md.		21c. (City or town) (County) Laurel Grove, St. Mary's, Md. (State) Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10 16 55 P.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fall off truck & under rear wheel.	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE: <i>Debra L. Jane</i>					
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 10/17/55		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. M. D. P. B. Robinson	
DATE REC'D BY LOCAL REG. 10 / 17 / 55		REGISTRAR'S SIGNATURE P. B. Robinson		DATE SIGNED 10/17/55	
24. FUNERAL DIRECTOR ADDRESS Leonardtown, Maryland.					



TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

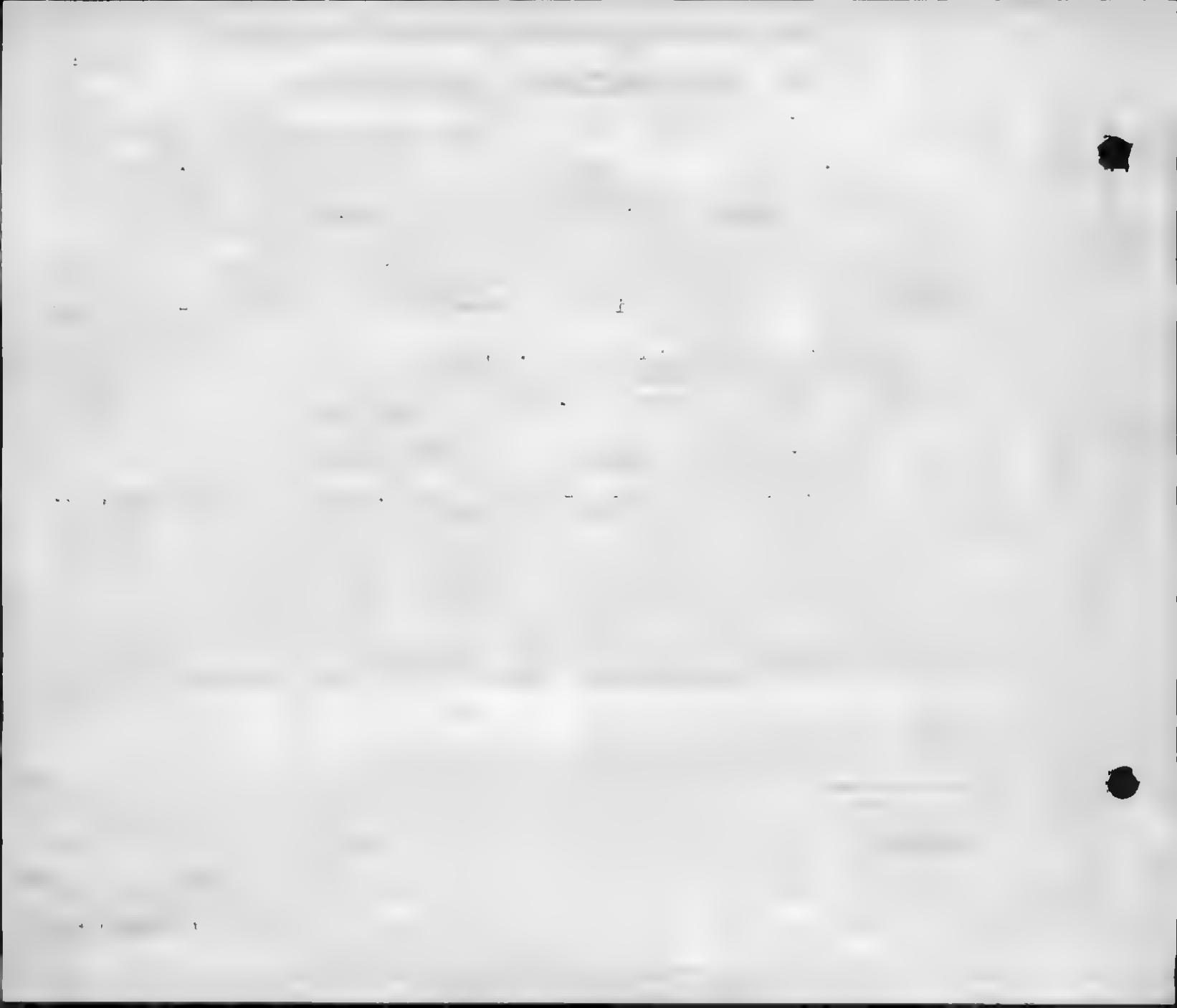
10099

CERTIFICATE OF DEATH

10105

Reg. Dist. No. 281

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	St. Marys Hermansville	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TOWN Hermansville STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Rural	
3. NAME OF DECEASED (Type or Print)		(First) Thomas	(Middle) Frederick
(Specify)		(Last) Hopewell	4. DATE OF DEATH 10 - 25 - 1955
S. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Feb. 12, 1888
9. AGE last birthday 67 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Deys	12. IF UNDER 24 HRS. Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School janitor		10b. KIND OF BUSINESS OR INDUSTRY State of Md.	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John Hopewell		14. MOTHER'S MAIDEN NAME Maria Chase	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 218-07-211	17. INFORMANT & ADDRESS Agnes P. Hopewell - Hermansville, Md.
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET AND DEATH 3 years 10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Jan. 19, 50, to Oct. 25, 1955, that I last saw the deceased alive on Oct. 15, 1955, and that death occurred at 8 P.M. from the causes and on the date stated above. SIGNATURE Dr. H. P. Patrick M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/28/55	NAME OF CEMETERY OR CREMATORIAL Holy Face Cemetery
24. REC'D BY REGISTRAR DATE 10/27/55		REGISTRAR'S SIGNATURE R. B. Murray, M.D. Dr. L. L. Lovell	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. H. Robinson - Lexington Park, Md.



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10100

CERTIFICATE OF DEATH

10106

Reg. Dist. No. 282

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	St. Mary's Rural Medley's Neck	MARYLAND LENGTH OF STAY (up to this place) 6 yrs.	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Medley's Neck STREET ADDRESS (If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
William Ernest Knott		10/ 19/ 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 11/3/1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		9. AGE last birthday 67 yrs.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or date of service) No	
16. SOCIAL SECURITY NO. 213-22-1335		17. INFORMANT & ADDRESS William E. Knott Medley's Neck, Md.	
18. MEDICAL CERTIFICATION 42.1 IMMEDIATE CAUSE (A) Coronary occlusion ANTECEDENT CAUSE(S) DUE TO (B) Coronary occlusion DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 hour 8 years	
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/3/1955</u> to <u>Oct 17, 1955</u> , that I last saw the deceased alive on <u>Oct 17, 1955</u> , and that death occurred at <u>10F</u> M, from the causes and on the date stated above. SIGNATURE <u>P. J. Bear</u> M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/22/55	
24. REC'D. BY REGISTRAR DATE Oct 20/55		NAME OF CEMETERY OR CREMATORIAL St. John's	
REGISTRAR'S SIGNATURE Heart Register		LOCATION (City, town, or county) Hollywood, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE Jos. C. Mattingley Leonardtown, Md.		ADDRESS	

OCT

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

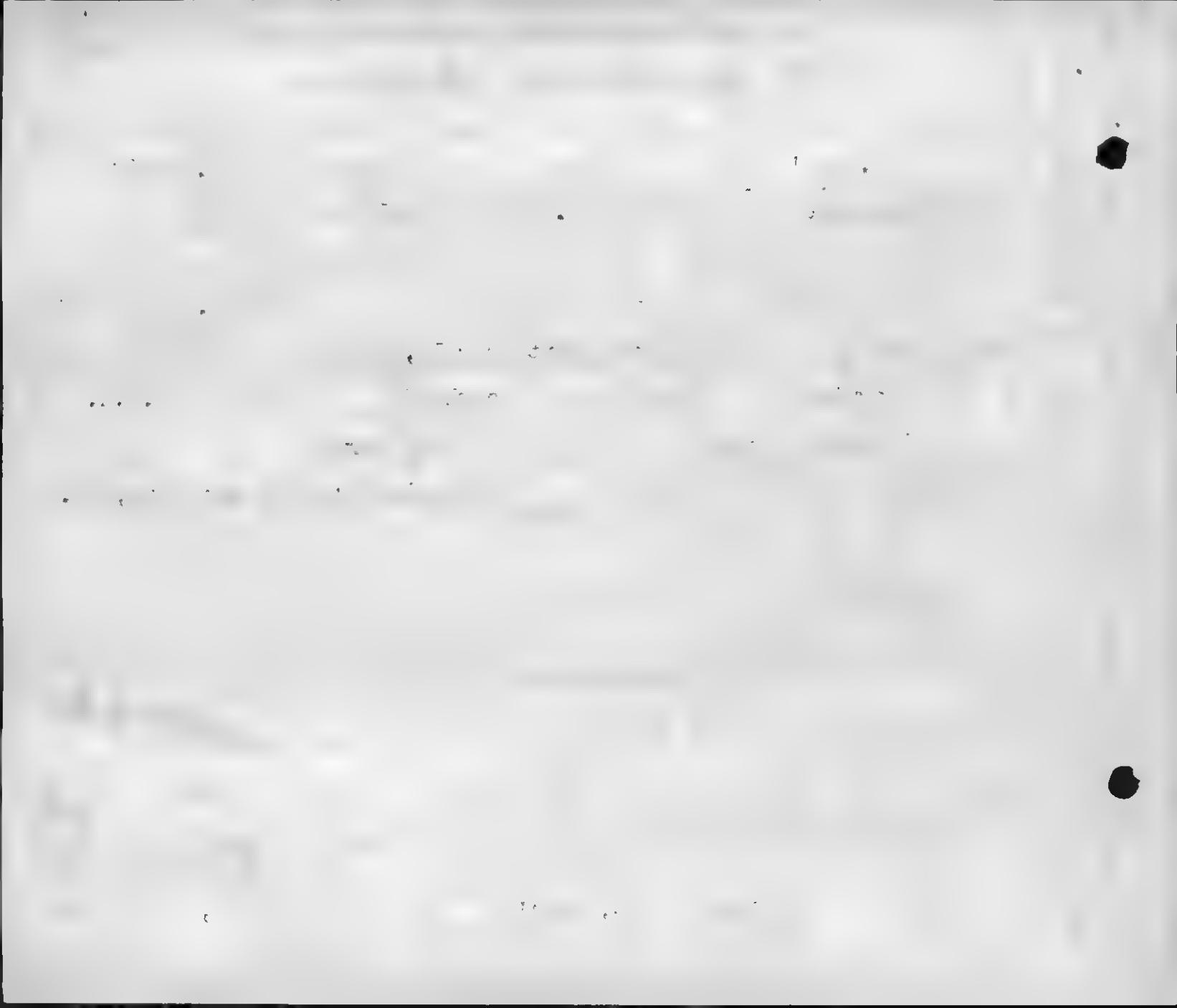
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10101

CERTIFICATE OF DEATH

Reg. Dist. No. 284

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	St. Mary's	MARYLAND LENGTH OF STAY (in this place)	Maryland CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Hollywood		40 yrs.	TOWN Hollywood
HOSPITAL OR INSTITUTION OR STREET ADDRESS oo		STREET ADDRESS	(If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
George Franklin McKay		Oct. 21 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH September 17, 1872
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	9. AGE last birthday 83 yrs.
13. FATHER'S NAME Mitchell McKay		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, blank.) NO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. NONE		14. MOTHER'S MAIDEN NAME Mary Cox	
17. INFORMANT & ADDRESS Manning McKay Leonardtown, Md.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE 420.1 (A) Coronary atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH is hours	
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) General arteriosclerosis		10 years	
(C)		16 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cholecystitis			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 21, 1955</u> , to <u>Oct. 21, 1955</u> , that I last saw the deceased alive on <u>Oct. 21, 1955</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>M. B. Cox</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 10/24/55	
24. REC'D BY REGISTRAR DATE <u>Oct. 22/55</u>		REGISTRAR'S SIGNATURE <u>M. B. Cox, M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Frederick W. Cox, M.D.</u>		LOCATION (City, town, or county) Hollywood, Maryland	



10102

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY STREET ADDRESS
X TOWNS HOSPITAL OR INSTITUTION OR STREET ADDRESS oo	Chaptico	Maryland Chaptico	St. Mary's
3. NAME OF DECEASED: (Type or Print)		(First) Barbara	(Middle) Villanova
		(Last) Miles	
5. SEX: Female		6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Maryland
13. FATHER'S NAME: George Frederick Miles		14. MOTHER'S MAIDEN NAME: Grace Mc Nelson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.: — — —	17. INFORMANT & ADDRESS: George F. Miles Chaptico, Md.
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 571.0 Immediate cause (a) Diarrhea Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause (b) . stating the underlying cause last. DUE TO (c)			
2. Interval Between Onset And Death 1 week			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY While at Work <input type="checkbox"/> At Work <input type="checkbox"/>	(CITY OR TOWN) How did injury occur?
22. I hereby certify that I attended the deceased from Oct. 3, 1955, to Oct. 4, 1955, that I last saw the deceased alive on Oct. 3, 1955, and that death occurred at 9:05 A.M. from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED D. Bean M.D. Great Mills Md. 10/4/55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE REC'D BY LOCAL REGISTRAR 10-4-1955		DATE THEREOF 10-6-1955 REGISTRAR'S SIGNATURE D. Bean M.D. Locate	NAME OF CEMETERY OR CREMATORIUM St. Joseph LOCATION (City, town, or county) Morganza Md ADDRESS
24. FUNERAL DIRECTOR, Joe C. Mattingly Leonardtown Md			

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10103

10109

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 231

1. PLACE OF DEATH:

COUNTY	St. Marys	MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		LENGTH OF STAY (in this place)
Lexington Park		3 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	U.S. Naval Hospital Patuxent River, Md.	

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE	Colorado	COUNTY	unknown
CITY (If outside corporate limits write RURAL and give nearest town) TOWN		Fort Collins	
STREET ADDRESS		(If rural, give location)	
		1601 North College Ave.	

44 X - 3

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)
Loren	Dale	Moody	

4. DATE OF DEATH	(Month)	(Day)	(Year)
10	-	24	- 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
male	white	married	11 - 1 - 1924

9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.
30	Months	Days
30 yrs.	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
U.S. Navy	U.S. Navy	Wyoming	USA

13. FATHER'S NAME:

E.N. Moody

14. MOTHER'S MAIDEN NAME:

Amy Willimson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.: (If Yes, give war or dates of service / to / to /)
yes	12/12/42 to 10/24/55

17. INFORMANT & ADDRESS:

Official Navy Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

975X

Immediate cause

(a) DUE TO

Penetrating bullet wound of brain

INTERVAL BETWEEN
ONSET AND DEATH
inde

Antecedent cause(s)

Diseases or conditions, if any, (b)....
giving rise to the above cause DUE TO
stating underlying cause last (c)II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

none

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

none

20. AUTOPSY?

Yes No

21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County)
injury	home	Lafayette Park, St. Marys, Md.

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? self inflicted with own revolver
10 24 55 6:30 A.M.		

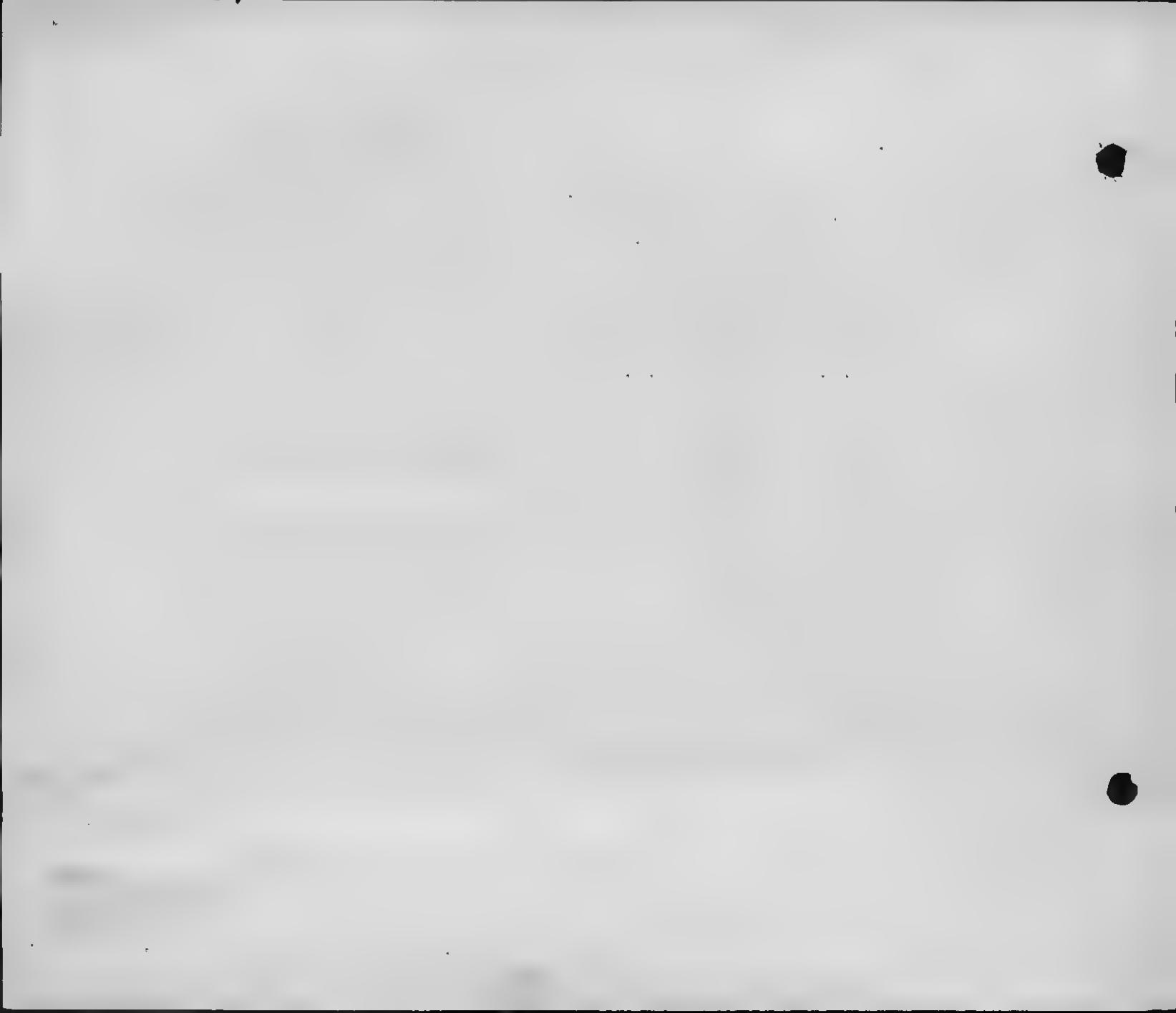
(State)

22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> SIGNATURE	CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM.	DATE SIGNED 10/26/55
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23. BURIAL, CREMATION, REMOVAL (Specify): Transportation	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG.	10/26/55	Jackson, Wyoming	

REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
W. Bean, M.A.	P.B. Robinson - Leonardtown, Maryland.	

Local



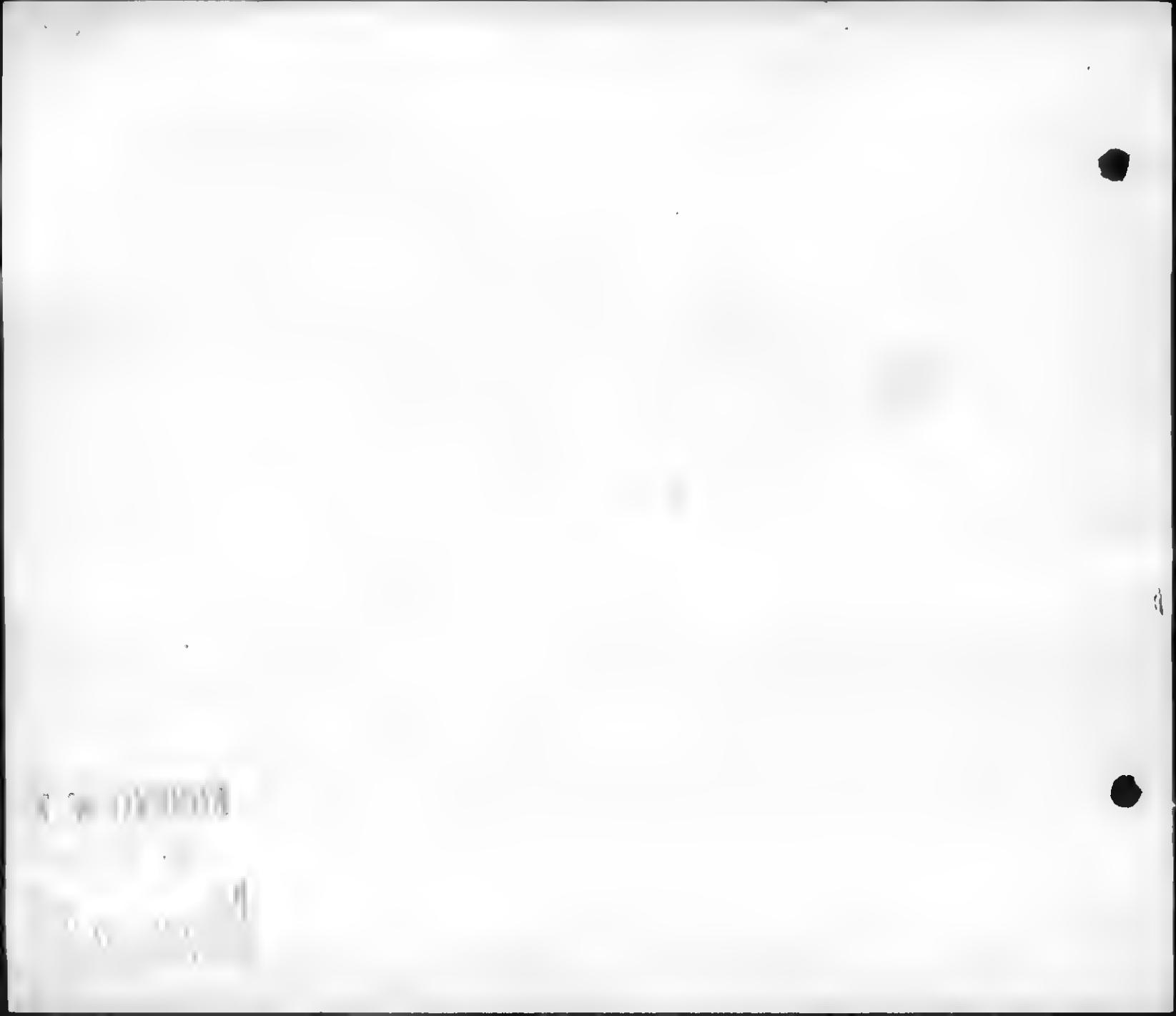
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10104 Items 2, 5, Filing 187 10-10-55 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <i>St. Mary's</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>St. Mary's</i>		CITY: If outside corporate limits, write RURAL and give nearest town.	
CITY (If outside corporate limits, write RURAL and give nearest town.) <i>Leonardtown</i>		LENGTH OF STAY (in this place)		OR		TOWN <i>Helen</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>St. Mary's Hospital</i>		STREET ADDRESS		(If rural give location)		X	
3. NAME OF DECEASED: (First) <i>Joseph</i> (Middle) <i>Infant</i> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <i>Oct 2 1955</i>					
(Type or Print)		5. SEX: 6. COLOR OR RACE: <i>Female White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Single</i>		8. DATE OF BIRTH: <i>Oct 1, 1935</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>—</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>—</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>John N. Morgan</i>		14. MOTHER'S MAIDEN NAME: <i>Hazel Samton</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT & ADDRESS: <i>John N. Morgan Helen, Md.</i>		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION: <i>—</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>762.5</i>		(A) IMMEDIATE CAUSE <i>Respiratory arrest</i>		21. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>—</i>		22. DATE (Month) (Day) (Year) (Hour) OF INJURY <i>—</i>	
ANTECEDENT CAUSE (S) <i>—</i>		(B) DUE TO <i>Prematurity, Prematurity</i>		23. WHERE DID INJURY OCCUR? (City or town) (County) (State) <i>—</i>		24. HOW DID INJURY OCCUR? <i>—</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>—</i>		(C) DUE TO <i>—</i>		25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>		26. MAJOR FINDINGS OF OPERATION <i>—</i>	
27. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>—</i>		28. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		29. ADDRESS <i>—</i>		30. DATE SIGNED <i>10/2/55</i>	
31. I hereby certify that I attended the deceased from <i>Oct 1, 1955</i> to <i>Oct 2, 1955</i> , that I last saw the deceased alive on <i>Oct 1, 1955</i> , and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above. SIGNATURE <i>Joseph E. Gill</i> ADDRESS <i>Leonardtown, Md.</i> DATE SIGNED <i>10/2/55</i>							
32. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>10/3/55</i>		NAME OF CEMETERY OR CREMATORIAL <i>St. Mary's</i>		LOCATION (City, town, or county) (State) <i>Leonardtown, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>10/3/55</i>		REGISTRAR'S SIGNATURE <i>—</i>		33. FUNERAL DIRECTOR <i>Glenn L. Shulman, Jr. C. Mattioli</i>		ADDRESS <i>Leonardtown, Md.</i>	



10105

10111

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 282

1. PLACE OF DEATH:

COUNTY St. Mary's MARYLAND
 CITY (If outside corporate limits, write RURAL
 OR and give nearest town)
 TOWN Rural Mechanicsville LENGTH OF STAY
 (in this place)
 18 yrs.

HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY St. Mary's
 CITY (If outside corporate limits write RURAL and give nearest town)
 OR
 TOWN Rural Mechanicsville
 STREET ADDRESS
 (If rural, give location)

3. NAME OF
DECEASED:
(Type or Print)

(First) Gertrude (Middle) Agnes (Last) Owens

4. DATE
OF
DEATH Oct. 17, 1955

5. SEX:

6. COLOR OR
RACE: Female white 7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) Married

8. DATE OF BIRTH:

9. AGE last birthday: January 27, 1894 61 (61) yrs.
 IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired) Housewife 10b. KIND OF BUSINESS OR
INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland 12. CITIZEN OF WHAT
COUNTRY? U.S.A.

13. FATHER'S NAME:

William Wathen

14. MOTHER'S MAIDEN NAME:

Sarah Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY NO.: 17. INFORMANT & ADDRESS:
Moses Owens Mechanicsville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

42
 Immediate cause (a) ...
 DUE TO

Coronary sclerosis

INTERVAL BETWEEN
ONSET AND DEATH

one day

Antecedent cause(s)
 Diseases or conditions, if any, (b) ...
 giving rise to the above cause DUE TO
 stating underlying cause last (c)

Arteriosclerosis

10-35

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

none

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

none

20. AUTOPSY?

Yes No

21a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH none

21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY

21c. (City or town) none (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
 OF INJURY none M. While at work Not while work

21f. HOW DID INJURY OCCUR?

none

22. I hereby certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and
 find that death resulted from: Natural causes Accident Suicide Homicide Undetermined cause
 SIGNATURE

CHIEF MEDICAL EXAMINER
 DEPUTY MEDICAL EXAMINER
 M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED
10/16/55

23. BURIAL, CREMATION,
 REMOVAL (Specify): DATE THEREOF NAME OF CEMETERY OR Crematory LOCATION (City, town, or county) (State)
Burial 10/19/55 St. Joseph's Morganza, Md.

24. FUNERAL DIRECTOR ADDRESS
 DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE
10-18-55 Glenn A. Hausey Jos. C. Mattingley Leonardtown, Md.

THE GENEVIEVE
MUSEUM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10106

CERTIFICATE OF DEATH

10112

Reg. Dist. No. 281

PLEASE TYPE OR WRITE—PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY St. Mary's MARYLAND		Delaware STATE Maryland COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL or and give nearest town) OR TOWN Patuxent River, Md. USNAS LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lexington-Park Claymont 44X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Station Hospital, U.S. Naval Air Station, Patuxent River, Md.		STREET ADDRESS 8307 Tower Street (give location) -295 Shintee-Drive (see birth cert.)	
3. NAME OF DECEASED. (First) Cindy (Middle) Lou (Last) Reese		4. DATE (Month) (Day) (Year) DEATH: Oct 22 1955	
5. SEX: Female RACE: Caucasian 6. COLOR OR 7. SINGLE, MARRIED, MARRIED, WIDOWED, DIVORCED. 8. DATE OF BIRTH: 10-21-55 9. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.		10. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		13. FATHER'S NAME: John R. Reese	
14. MOTHER'S MAIDEN NAME: Margaret Ann Brown		15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service: -----	
16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS: John R. Reese Address: same as # 2	
18. MEDICAL CERTIFICATION		19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
776X IMMEDIATE CAUSE (A) Prematurity, Neonatal death DUE TO		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO		21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 22. DATE OF OPERATION: 23. BURIAL, CREMATION, REMOVAL (SPECIFY) DATE THEREOF	
24. FUNERAL DIRECTOR ADDRESS		25. PLACE (Home, farm, factory, street, office bldg., etc.) 26. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
27. DATE PEC'D BY LOCAL REGISTRAR 10-24-55		28. DATE OF INJURY 10-21-55 29. DATE INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
30. REGISTRAR'S SIGNATURE P. J. Beary M/S Local		31. DATE OF DEATH 10-22-55 32. DATE OF BURIAL 10-24-55 33. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) Claymont, Delaware	



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10107

CERTIFICATE OF DEATH

10113
282

Reg. Dist. No. 282

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	St. Marys	MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	District of Columbia Washington
HOSPITAL OR INSTITUTION OR STREET ADDRESS 78 St. Marys Hospital		LENGTH OF STAY (In this place) 14 hrs.	
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last) William Leonard Stevens	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Feb. 19, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Temple Motors	9. AGE last birthday 55 yrs.
13. FATHER'S NAME Temple Stevens		14. MOTHER'S MAIDEN NAME Elizabeth Hughes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 577-16-0137	
17. INFORMANT & ADDRESS 1421-19th St. S.E.		18. MEDICAL CERTIFICATION Intestinal hemorrhage Bleeding Meckel's diverticule or stomach ulcer 14 hrs	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 540.0 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10.30, 1955, to 10.31, 1955, that I last saw the deceased alive on 10.30, 1955, and that death occurred at 6 A.M. from the causes and on the date stated above. SIGNATURE branford			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11/2/55	NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery
24. REC'D BY REGISTRAR DATE 10/31/55		REGISTRAR'S SIGNATURE Alan S. Housery	LOCATION (City, town, or county) Bladensburg, Maryland, (State)
25. FUNERAL DIRECTOR'S SIGNATURE Davis		ADDRESS 1661 Good Hope Rd. S.E. Wash. D.C.	

CERTIFICATE OF SERVICE

1001

HAROLD L. COLEMAN

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BUREAU V. S.

-MAY 5 1955

RECEIVED

1001

1001

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10114

10108 CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		St. Marys MARYLAND Callaway		STATE Maryland COUNTY St. Marys CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Callaway		STREET ADDRESS (If rural give location) Rural	
3. NAME OF DECEASED (Type or Print) James				4. DATE OF DEATH 10 - 29 1955			
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH May 7, 1875	9. AGE last birthday 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming				11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME William Thompson				12. CITIZEN OF WHAT COUNTRY? USA			
14. MOTHER'S MAIDEN NAME Sophia Briscoe				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no			
16. SOCIAL SECURITY NO. -----				17. INFORMANT & ADDRESS Nellie B. Thompson, Callaway, Md.			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Coronary thrombosis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) General arteriosclerosis 2 months							
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION /				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1, 1955, to Oct 29, 1955, that I last saw the deceased alive on Oct 28, 1955, and that death occurred at 3:15 P.M., from the causes and on the date stated above. SIGNATURE <i>John W. Briscoe</i> M.D. ADDRESS (Street, city, town, state) <i>Point Mill Rd</i> DATE SIGNED <i>10/30/55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11/2/55		NAME OF CEMETERY OR CREMATORIAL St. Georges Cemetery		LOCATION (City, town, or county) Valley Lee, Maryland (State)	
24. REC'D BY REGISTRAR DATE <i>Oct 30/55</i>		REGISTRAR'S SIGNATURE <i>John W. Briscoe</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>P.B. Johnson</i>		ADDRESS Leonardtown, Md.	

